



Medical Quality Assurance Commission  
 P.O. Box 47866  
 Olympia, WA 98504-7866  
 A-L 360.236.2766  
 M-Z 360.236.2765

## **Physician and Surgeon Expired License Activation Application Packet (Expired Over Three Years)**

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These are the standard forms you should find within this application packet. Any forms may be copied as needed. There are additional requirements for which there are no forms available; please read the instructions carefully in order to understand all that is required in order to be issued a license.

### **Important Social Security Number Information:**

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.2750 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

#### **Mail your application with your check or money order payable to:**

Department of Health  
 PO Box 1099  
 Olympia, WA 98507-1099

#### **Send additional documents to:**

Medical Quality Assurance Commission  
 PO Box 47866  
 Olympia, WA 98504-7866

#### **Contact us:**

A-L 360.236.2766  
 M-Z 360.236.2765

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Washington State Department of  
**Health**  
Medical Quality Assurance Commission  
P.O. Box 47866  
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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the correct forms required.

**Application Fee.** (This fee is non-refundable). You can check the [fee page](#) for current fees.

**Step #1: Demographic Information:**

**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360.236.2750 if you do not have one.

**Legal Name:** List your full name.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the city, state, and country where you were born.

**Address:** List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if applicable.

**Email:** Enter your email address, if applicable.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**Step #2: Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- “Another jurisdiction” means any other country, state, federal territory, or military authority.

- Step #4: Professional Experience:**  
In chronological order, list all professional work experience since you received your medical degree. If you need more space, attach a piece of paper.
- Step #5: Previous Licenses in Other States:**  
List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current. If you need more space, attach a piece of paper.
- Step #6 Hospital Privileges:** (Excluding post graduate training)  
List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five years. If you need more space, attach a piece of paper.
- Verifications must be received directly from each hospital. This does not include post graduate training hospitals.
  - Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, the Human Resource Command, 1 Reserve Way, St. Louis, MO 63132.
  - Locum Tenens: Hospital privileges of a 30-day or longer duration.
- Step #7: AIDS Education and Training Attestation:**  
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training, required by [WAC 246-12-260](#) course content can be found at [WAC 246-12-270](#).
- Step #8: Applicant's Photograph:**  
Attach a current photograph in the box provided or attach to the application. Indicate the date the photograph was taken. Sign in ink across the bottom of the photo. The photograph must be a clear, close up, with a front view of applicant.
- Step #9: Applicant's Attestation:**  
You must sign and date this for us to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

**AMA and FSMB Profiles:**

The department staff will obtain the American Medical Association (AMA) Physician profile report and the Federation of State Medical Boards (FSMB) data bank clearance report. However, if staff is unable to obtain the reports electronically, the applicant will be required to submit requests and pay any applicable fees.

## **Important Information**

It is very important that you allow twelve to sixteen weeks to process your application. Physician, and surgeon application and temporary permit fees are located at:

<https://fortress.wa.gov/doh/hpqa1/hps5/Medical/fees.htm>.

**WAC 246-919-990 Physician and surgeon fees and renewal cycle.** Licenses must be renewed every two years on the practitioner's birthday.

**WAC 246-12-310 Address changes.** It is the responsibility of each practitioner to maintain his or her current address on file with the department. Requests for address changes may be made either by telephone or in writing. The mailing address on file with the department will be used for mailing of all official matters to the practitioner.

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Medical Quality Assurance Commission  
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360.236.4700

## **Additional Information and Instructions**

**Important Note** for applicants who have not practiced clinical medicine for more than two years.

If an applicant has **not practiced clinical medicine for two or more years**, the Commission may require the applicant to do one or more of the following:

- Pass the Federation of State Medical Boards Special Purpose Examination (SPEX). You can contact them at 817.868.4000 or visit their website at [www.fsmb.org](http://www.fsmb.org).
- Undergo a knowledge and skills assessment at The Center for Personalized Education for Physicians CPEP 303.750.7150 or [www.cpepdoc.org](http://www.cpepdoc.org).
- Undergo a knowledge and skills assessment at the University of California at San Diego School of Medicine, Physician Assessment and Clinical Education Program (PACE) 619.543.6770 or <http://www.paceprogram.ucsd.edu/>.
- Successfully complete an additional year or more of post-training, accredited through the Accreditation Council for Graduate Medical Education, and pre-approved by the Commission.
- Complete any other examination or assessment the Commission deems appropriate.

Once the Commission requests an applicant to complete one of these requirements, the Commission will not permit the applicant to withdraw the application. If the applicant does not successfully comply with the Commission's request to complete one of the above items, the Commission may deny the application.

The Commission cannot refund application fees. [WAC 246-12-340](#).

This application is for medical school graduates only.

### **Important Information**

Prior to applying for license, please read through carefully and consider all the following laws on applications:

- The following conduct, acts or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter.
- Fees submitted with applications for credentialing, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable.
- An application for a license may not be withdrawn after the commission or the reviewing commission member determines that grounds exist for denial of the license or for the issuance of a conditional license.

After the application and fees have been received by the Department of Health, the applicant will be notified if any documents or data are missing. Applicants should allow a minimum of twelve to sixteen weeks for processing. Only complete applications will be considered for review. Routine applications require five days for processing. Non-routine applications require more time for processing. All information, documents, data, etc. provided to the department by the applicant will become a part of the file.

**Note:** It is the responsibility of the applicant to submit the correct forms to the appropriate entities to obtain verification information in support of the application for a physician license. Documents submitted in support of the application must be submitted directly from the originating source. Copies of post graduate certificates, licenses, hospital privileges, and examination scores, will not be accepted.

Applications that are pending for one year will become invalid, along with the fee and any other supporting documentation. After that time, it will be necessary to begin the process over with a new application, current fee, and all supporting documents.



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## Physician and Surgeon Expired License Activation Application

### 1. Demographic Information

|  |  |
|--|--|
| <b>Social Security Number</b> (If you do not have a social security number, see instructions.)<br>—                      — | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
|--|--|

|      |       |        |      |
|------|-------|--------|------|
| Name | First | Middle | Last |
|------|-------|--------|------|

|                         |                |       |         |
|-------------------------|----------------|-------|---------|
| Birth date (mm/dd/yyyy) | Place of birth |       |         |
|                         | City           | State | Country |

Address

|      |       |     |        |
|------|-------|-----|--------|
| City | State | Zip | County |
|------|-------|-----|--------|

Country

|                  |                |                 |
|------------------|----------------|-----------------|
| Phone (        ) | Fax (        ) | Cell (        ) |
|------------------|----------------|-----------------|

Email address

Mailing address (if different from above)

|      |       |     |        |
|------|-------|-----|--------|
| City | State | Zip | County |
|------|-------|-----|--------|

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)?  Yes  No    If yes, list name(s):

Will documents be received in another name?  Yes  No  
If yes, list name(s):

### Medical Specialty

Medical school \_\_\_\_\_ Year of graduation \_\_\_\_\_  
 Medical specialty \_\_\_\_\_

**2. Personal Data Questions**

Yes No

- 1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

- 2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

- 3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

- 4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

- 5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

**2. Personal Data Questions (Cont.)**

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .....

**Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.**

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .....
- 6. Have you ever been found in any civil, administrative or criminal proceeding to have:
  - a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
- 7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
- 8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
- 9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
- 10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
- 11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? .....
- 12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? .....
- 13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? .....
- 14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? .....

### 3. Medical Education and Experience

Provide a chronological listing of your educational preparation training. If you need more space, attach a piece of paper.

| Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.) | Diploma or degree obtained (Quote titles in original language and translate to English.) | Number of years attended | Dates granted |             |
|---|--|--------------------------|---------------|-------------|
|   |  |                          | Start mm/yyyy | End mm/yyyy |
| Medical education (list all medical schools attended)   |  |                          |               |             |
|   |  |                          |               |             |
|   |  |                          |               |             |
|   |  |                          |               |             |
|   |  |                          |               |             |
|   |  |                          |               |             |

### 4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

| Name and location of institution | From (mm/dd/yyyy) | To (mm/dd/yyyy) | Nature of experience or specialty |
|----------------------------------|-------------------|-----------------|-----------------------------------|
|                                  |                   |                 |                                   |
|                                  |                   |                 |                                   |
|                                  |                   |                 |                                   |
|                                  |                   |                 |                                   |
|                                  |                   |                 |                                   |

### 5. Hospital Privileges (Excluding post-graduate training hospital privileges.)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

| Name of hospital | Dates attended        |                     |
|------------------|-----------------------|---------------------|
|                  | Start date mm/dd/yyyy | End date mm/dd/yyyy |
|                  |                       |                     |
|                  |                       |                     |
|                  |                       |                     |
|                  |                       |                     |
|                  |                       |                     |
|                  |                       |                     |

## 6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current.

| State | Date license issued | License Number | Basis of License |             | Status of license | Any limitations on license                               |
|-------|---------------------|----------------|------------------|-------------|-------------------|--|
|       |                     |                | Exam date passed | Endorsement |                   |  |
|       |                     |                |                  |             |                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|       |                     |                |                  |             |                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|       |                     |                |                  |             |                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|       |                     |                |                  |             |                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |

## 7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four (4) of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

|                      |      |
|----------------------|------|
| Applicant's initials | Date |
|----------------------|------|

## 8. Applicant's Photograph

### Photo Here



Attach current photograph here. Indicate date taken and sign in ink across bottom of the photo.

NOTE: Photograph **must** be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view of applicant
5. Instant polaroid photographs **not** acceptable

Height \_\_\_\_\_

Weight \_\_\_\_\_

Hair color \_\_\_\_\_

Color of eyes \_\_\_\_\_

## 9. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the  
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ at \_\_\_\_\_ (city, state)

By: \_\_\_\_\_  
Signature of applicant



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**MD**

## Professional Liability Action History

Applicant's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.

Date of occurrence: \_\_\_\_\_ Details: \_\_\_\_\_

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2. Date suit or claim was filed: \_\_\_\_\_ Name and address of insurance carrier that handled the claim:

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3. Your status in the legal action (primary defendant, codefendant, other): \_\_\_\_\_

4. Current status of suit or other action: \_\_\_\_\_

5. Date of settlement, judgment, or dismissal: \_\_\_\_\_

6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount.

**You must enclose a copy of final disposition of case this includes dismissals. \$** \_\_\_\_\_

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**MD**

**To: State Medical Licensing**

Name of licensing agency \_\_\_\_\_

Address \_\_\_\_\_

**RE: Verification of license/registration as a physician**

I am applying for a license to practice medicine as a physician and surgeon in the state of Washington and before my application can be reviewed, a verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

Applicant (print or type) \_\_\_\_\_ Birth date \_\_\_\_\_

Signature of applicant \_\_\_\_\_

This is verify that \_\_\_\_\_ was issued license number \_\_\_\_\_ on \_\_\_\_\_

1. Date license, registration, or certification expires
2. Have any complaints been lodged against the license? .....  Yes  No
3. Is there currently any investigation in process regarding the license? .....  Yes  No
4. Has any disciplinary activity taken place regarding this license? .....  Yes  No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

**Return to:**

Medical Quality Assurance Commission  
 P O Box 47866 Olympia, WA 98504-7866

Signature \_\_\_\_\_

Title \_\_\_\_\_

Please type or print

Hospital \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Telephone \_\_\_\_\_

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**To: Hospital Administration (Excluding post-graduate training hospital privileges)**

Hospital Name \_\_\_\_\_

Address \_\_\_\_\_

**RE: Verification and evaluation of privileges**

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

Applicant name \_\_\_\_\_ Birth date \_\_\_\_\_  
Print or type mm/dd/yyyy

Signature of applicant \_\_\_\_\_

1. \_\_\_\_\_ has/had admitting or specialty privileges at this hospital  
 from \_\_\_\_\_ to \_\_\_\_\_  
mm/yyyy mm/yyyy

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?  
 Yes  No If yes, please explain \_\_\_\_\_

3. Has the applicant ever been asked to resign?  Yes  No If yes, please explain \_\_\_\_\_

4. Did the applicant ever resign in lieu of or to avoid adverse action?  Yes  No

5. Has a report concerning the applicant ever sent to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank?  Yes  No

**Return to:**

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Signature \_\_\_\_\_

Print Name \_\_\_\_\_

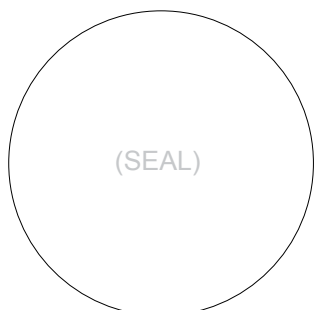
Title \_\_\_\_\_

Medical Institution \_\_\_\_\_  
Please type or print

Address \_\_\_\_\_

Date \_\_\_\_\_

Telephone \_\_\_\_\_



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## **Health Professions Reference Numbers and Links**

### **RCW/WAC Links**

Uniform Disciplinary Act,  
UDA RCW 18.130.....<http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130>

Administrative Procedure Act,  
APA RCW 34.05 .....<http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05>

Administrative procedures and requirements,  
WAC 246-12 .....<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-12>

### **On-Line**

Medical Quality Assurance  
Commission.....<https://fortress.wa.gov/doh/hpqa1/hps5/Medical/default.htm>